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# EXHIBIT B – Provider Registration Declaration

Please note that providers can enrol a pharmacy or update pharmacy information faster and more conveniently by logging into the Express Scripts Canada (ESC) Pharmacy Provider Website at https://provider.express-scripts.ca.

All supporting documents and pages of this form must be submitted by:

**Upload to:** ESC Pharmacy Provider Website under the section Communications – Provider Relations (applicable to pharmacy information updates only) https://provider.express-scripts.ca

**Fax to:** 1 855 622-0669 or

**Mail to:** Express Scripts Canada Attention: Provider Relations
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5

ESC Provider Number(s):

Effective Date (YYYY-MM-DD):

Type of Request, please check all of those that apply:

- ☐ New opening
- ☐ Change in ownership/directors and/or officers
  - ☐ Change in legal business name
  - ☐ Change in owners, directors and/or officers, i.e., adding or removing
  - ☐ Amalgamation of companies
- ☐ Set up Electronic Funds Transfer (EFT) or change to EFT (electronic funds transfer)/ direct deposit/ bank account information
- ☐ Change in pharmacy operating address
- ☐ Change in pharmacy banner/chain operating name
- ☐ Change in pharmacy dispensing fee
- ☐ Other: specify: _____

Documents that must be submitted:

- ☐ Governance documents that list the names of all owners of the company, partnership or entity
- ☐ Certificate of liability insurance (if the request is for a new opening or change in ownership)
- ☐ Void cheque with legal business name clearly stated on the cheque
- ☐ Copy of pharmacy accreditation certificate or correspondence with the regulatory body
- ☐ If the pharmacy operates or will be operating in the territories, a copy of the business license
- ☐ All pages of Exhibit B (write N/A on blank pages)
- ☐ A list of all additional fully or partially owned pharmacies by any owner, director or officer. This can be added on the Exhibit B itself or provided on a separate sheet if there are multiple pharmacies to list. The list must include the ESC provider number (if applicable), operating name, and complete pharmacy operating address.

## SECTION A: Provider Business Information

| Type of Business | Legal Business Name *(must match Provider's governance documents (Articles of Inc., Partnership Agreement, etc.), a copy of which you are required to submit with this Agreement.* ***Failure to provide all applicable documents may cause delays of this application and/or its denial.*** | | |
|---|---|---|---|
| ○ Corporation<br>○ Sole Proprietorship<br>○ Partnership | | | |
| Business Address | | | |
| City | | Province | Postal Code |
| Telephone | Fax | Email | |

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**Owners, Officers and Directors of the Pharmacy (complete as many as necessary)**

*Please list all ESC Provider numbers where an owner, officer or director is also an owner, officer or director in any additional pharmacies. If more than six owners, officers and/or directors, please print and attach additional copies of this page. *If applicable*

| | | | |
|---|---|---|---|
| 1 Name *(first and last)* | | | |
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other:_____ | | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name | |
| Pharmacy Address | | | |
| City | Province | Postal Code | |
| 2 Name *(first and last)* | | | |
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other:_____ | | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name | |
| Pharmacy Address | | | |
| City | Province | Postal Code | |
| 3 Name *(first and last)* | | | |
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other:_____ | | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name | |
| Pharmacy Address | | | |
| City | Province | Postal Code | |

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| 4 Name *(first and last)* | | |
|---|---|---|
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other: _____ | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name |
| Pharmacy Address | | |
| City | Province | Postal Code |

| 5 Name *(first and last)* | | |
|---|---|---|
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other: _____ | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name |
| Pharmacy Address | | |
| City | Province | Postal Code |

| 6 Name *(first and last)* | | |
|---|---|---|
| Pharmacy College Registration (License) Number* | Position/Title:<br>◯ Owner ◯ Officer<br>◯ Director ◯ Other: _____ | |
| Additional Pharmacy(ies) Owned | ESC Provider Number(s)* | Pharmacy Operating Name |
| Pharmacy Address | | |
| City | Province | Postal Code |

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Have any of the Owners, Officers, Directors or Pharmacists listed above ever applied and been denied an ESC or Eclipse Provider Number?

◯ No ◯ Yes →Name(s):

Details

Have any of the Owners, Officers, Directors or Pharmacists listed above had an ESC or Eclipse Provider Number and lost billing privileges?

◯ No ◯ Yes →Name(s):

Details

Do any of the Owners, Officers, Directors or Pharmacists listed above have any pending concerns at their respective regulatory body(ies)?

◯ No ◯ Yes →Name(s):

Details

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# SECTION B: Pharmacy Information

(If registering more than one pharmacy under the same Provider legal entity, make additional copies of section B)

| | | | | |
|---|---|---|---|---|
| Language<br>◯ English ◯ French | | ESC Provider Number | | Pharmacy License/ Accreditation Number |
| Pharmacy Operating Name | | | Banner/ Chain Name | |
| Pharmacy Address | | | | |
| City | | | Province | Postal Code |
| Pharmacy Telephone | Pharmacy Fax | | Pharmacy Email | |
| Pharmacy Commercial General Liability Insurance *(include certificate for general commercial liability insurance, including minimum coverage amount. See Section 4.A. of the Agreement)* | | Usual and Customary Professional Fee<br>$ | | Ontario ONLY: Ontario Drug Benefit (ODB) Dispensing Fee<br>$ |
| Pharmacy Manager Name *(first and last)* | | | Pharmacy Manager's Registration License Number | |

**If purchasing an existing pharmacy, please indicate the following:**

| | | | |
|---|---|---|---|
| Existing Legal Entity | | | |
| Existing Operating Name | | | |
| Existing Address | | | |
| City | | Province | Postal Code |
| Existing Telephone | Existing Fax | Existing Email | |
| Existing Pharmacy's Provider Number | | | |

**Payment Information – Electronic Funds Transfer (EFT):**

On behalf of the Provider, I instruct ESC to set up or update the Provider's direct EFT payments. This form authorizes deposits to the bank account indicated and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. The Provider will advise ESC promptly of any changes to the bank, branch or account number. The Provider understands that EFT is the only payment option available for claims reimbursement.

| **Banking Information**<br>Attach: ◯ VOID Cheque OR ◯ Official Bank Letter<br>*A copy of a pre-printed VOID cheque or Official Bank Letter is required. Provider's details must be included on either the VOID Cheque or Official Bank Letter. If the attached cheque is not pre-printed with the Provider's legal and/or operating name, please provide a letter signed by an officer of the Provider's bank, indicating the account number and certifying the Provider as the account holder.* | | |
|---|---|---|
| Account Holder Name | | |
| Institution No. / Bank Code | Branch/ Transit No. | Account No. |

## Acknowledgment and Agreement

By signing this declaration, the Provider is aware that the information provided may be validated and audited by ESC at any time, and that any change in the original declaration requires a re-application by the Provider. Providers shall notify ESC in writing of any change or adjustment to information above in compliance with section 4 of the Pharmacy Provider Manual.

| | |
|---|---|
| | By initialing the box to the left of this statement, I (the signatory) warrant and confirm, on behalf of the Provider, that:<br>I have read the Pharmacy Provider Manual and the Provider acknowledges that the Pharmacy Provider Manual forms part of the Agreement.<br>The Provider acknowledges and agrees to be bound by all provisions within the Pharmacy Provider Agreement and Pharmacy Provider Manual, including and not limited to the following Pharmacy Provider Manual provisions: 2.6 ESC Services and Service Fees, 3.1 Pharmacy Provider Agreement, 4.2 Change of Pharmacy Provider Information, 5.3 Compliance Packaging and Frequent Dispensing, 10.1 Claim Submission Requirements- General, and 11.3 Extemporaneous Preparations/Compound Claim Submission Guidelines. |

Completed by:

| Signature of individual with authority to bind the Provider (**no stamps**) | Printed Full Name of Signatory |
|---|---|
| | Position/Title of Signatory |
| | Date Signed (YYYY-MM-DD)<br>5/28/25 |
| ☐ **By checking this box, I (the signatory) confirm that I have authority to bind the Provider to the terms of the Agreement.** | |